Antiasthmatic Monoclonal Antibodies
(CinQair, Dupixent, Fasenra, Nucala, Xolair)

Member and Medication Information (required)	
Member ID:	Member Name:
DOB:	Weight:
Medication Name/ Strength:	Dose:
Directions for use:	

Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:

FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992

Circle the diagnosis and medication, then complete the appropriate criteria part(s).

Diagnosis and Age Limitations	Complete	CinQair Preferred	Dupixent *Non-preferred	Fasenra Preferred	Nucala *Non-preferred	Xolair Preferred
Severe asthma w/ eosinophilic phenotype	Part: 1, 2	18 yrs. or older	6 yrs. or older	12 yrs. or older	6 yrs. or older	
Hypereosinophilic syndrome	Part: 1, 2				12 yrs. or older	
Eosinophilic granulomatosis w/ polyangiitis	Part: 1, 2, 3				18 yrs. or older	
Moderate to severe persistent asthma	Part: 1, 2, 4		6 yrs. or older			6 yrs. or older
Chronic idiopathic urticaria	Part: 1, 5					12 yrs. or older
Nasal polyps in adults (add-on therapy)	Part: 1, 6					18 yrs. or older
Chronic rhinosinusitis w/ nasal polyposis	Part: 1, 7		18 yrs. or older		18 yrs. or older	
Moderate-to-severe atopic dermatitis	Part: 1		6 yrs. or older			
Other FDA-Approved indication	Part: 1					

Part 1 *Criteria for Approval for all Indications:*

- ❑ The prescriber is or has consulted with: ❑ Allergist ❑ Pulmonologist ❑ Immunologist ❑ Dermatologist ❑ Otolaryngologist
- ❑ Documented diagnosis of requested indication. Chart Note Page #: _____
- ❑ Describe other treatment(s) the patient currently takes.
  Medication(s): _____ Chart Note Page #: _____
  Dates of therapy: _____

Part 2 *Additional Criteria for the Following Indications: Severe asthma/eosinophilic phenotype, Hypereosinophilic syndrome, Eosinophilic granulomatosis/polyangiitis, and Moderate to severe persistent asthma:*

- ❑ Minimum 3-month trial and failure or contraindication of at least one high dose inhaled corticosteroid / long acting beta agonist combination product.
  Medication(s): _____ Chart Note Page #: _____
  Dates of therapy: _____ Details of Failure: _____
- ❑ Trial and failure or contraindication of add-on tiotropium or leukotriene receptor antagonist therapy:
  Medication(s): _____ Chart Note Page #: _____
  Dates of therapy: _____ Details of Failure: _____
- ❑ Baseline eosinophil value has been obtained. Baseline value #: _____ Chart Note Page #: _____

Part 3 *Additional Criteria for Eosinophilic Granulomatosis with Polyangiitis (EGPA)*

- ❑ Trial and failure within the past year or contraindication to oral corticosteroid therapy:
  Medication(s): _____ Chart Note Page #: _____
  Dates of therapy: _____ Details of Failure: _____

Part 4 *Additional Criteria for Moderate to Severe Persistent Asthma:*

- ❑ Positive skin test or in vitro reactivity to a perennial aero-allergen. Chart Note Page #: _____
- ❑ For dosing, include the patient's baseline IgE value (30 – 1,300 IU/ml): _____
- ❑ Include the patient's baseline weight (20 – 150 kg): _____
- ❑ For Dupixent; to be use as add-on for eosinophilic phenotype or oral corticosteroid-dependent. Chart Note Page #: _____

Part 5 *Additional Criteria for Chronic Idiopathic Urticaria (CIU):*

- ❑ Minimum 2-month trial and failure of at least ONE of the following add on therapies:

  H2 antagonist: _____ Chart Note Page #: _____
  Dates of therapy: _____ Details of Failure: _____

  Leukotriene receptor antagonist: _____ Chart Note Page #: _____
  Dates of therapy: _____ Details of Failure: _____

Part 6 *Additional Criteria for Nasal Polyps in Adults: (Add-on therapy)*

- ❑ Minimum 2-month trial and failure of at least ONE nasal corticosteroid:

  Medication(s): _____ Chart Note Page #: _____
  Dates of therapy: _____

Part 7 *Additional Criteria for Chronic Rhinosinusitis with Nasal Polyposis:*

- ❑ Trial and failure of Both nasal corticosteroid and oral corticosteroid within the past year:

  Medication(s): _____ Chart Note Page #: _____
  Dates of therapy: _____

  Medication(s): _____ Chart Note Page #: _____
  Dates of therapy: _____

*** Non-Preferred Product:** *(Criteria above must also be met)*

- ❑ Minimum 3-month trial and failure of at least one preferred Monoclonal Antibody, or prescriber must demonstrate medical necessity for non-preferred product.

  Medication(s): _____ Chart Note Page #: _____
  Dates of therapy: _____ Details of Failure: _____

Off Label or Compendia Use of FDA-Approved Drugs Additional Criterion:
Requests for any off-label indications must be supported by at least one (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet or other peer review specialty medical journals within the most recent five (5) years. Supporting documentation must be included. Compendia use must be recommended by generally-accepted compendia such as American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (USP-DI), and the DRUGDEX Information System.
Diagnosis: _____ Duration of treatment: _____

Re-authorization Criteria: *Please submit pre-treatment and current information*
Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

Initial Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

Notes:

- ❖ Use appropriate HCPCS code for billing
  Coverage and Reimbursement code look up: https://health.utah.gov/stplan/lookup/CoverageLookup.php
  HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php
- ❖ Patient must have regular appointments to receive or follow up on the medication in the prescriber's office. The patient must remain in the office for an adequate amount of time to allow for observation and treatment of anaphylaxis, if necessary. If/when any change of dose is requested, the prescriber must indicate, in writing, the reasoning for the dose increase.

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date